DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03-04**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
8/13/03

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR PART 438

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 - 2004 00.00
b. FFY 2004 - 2005 00.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
9, 9(c)-9(s), 11, 22, 41, 45(a), 45(b), 46, 50(a), 54, 55, 71, 77, 78(a), List of Attachments Page 1, Attachment 2.2-A Page 10, Attachment 2.2-A Page10(a) and Attachment 4.30 Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
9, 9(c)-9(h), 11, 22, 41, 45(a), 45(b), 46, 50(a), 54, 55, 71, 77, 78(a), List of Attachments Page 1, Attachment 2.2-A Page 10, Attachment 2.2-A Page 10(a) and Attachment 4.30 Page 2

10. SUBJECT OF AMENDMENT:
Change for Managed Care due to the Balanced Budget Act (BBA) of 1997 federal legislation.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Carmen Hooker Odom

13. TYPED NAME:
Carmen Hooker Odom

14. TITLE:
Secretary

15. DATE SUBMITTED:
9/3/03

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 9, 2003

18. DATE APPROVED:
November 18, 2003

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
August 13, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Susan Cuerdon

21. TYPED NAME:
Susan Cuerdon

22. TITLE:
Acting Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:
CMS has identified and created templates for the pages of the State Plan that need amendments to ensure compliance with Federal regulations. In a June 30th State Medicaid Letter, CMS requests that the State Plan Amendments be submitted to them before the end of the third quarter in order to be effective by August 13.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State North Carolina

Citation		
42 CFR 431.12(b) AT-78-90	1.4 State Medical Care Advisory Committee	There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.
42 CFR 438.104	_X_	The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Citation:
1932 of the
Social Security Act

1.6 State Option to Use Managed Care

I. CITATION: SECTION 1932 (A)(1)(A) OF THE SOCIAL SECURITY ACT

The State of North Carolina proposes to enroll Medicaid beneficiaries on a mandatory basis into managed care entities (i.e. MCOs and PCCMs) in the absence of section 1115 or section 1915 (b) waiver authority. This authority is granted under section 1932 (a)(1)(A) of the Social Security Act (the Act). Under this authority, a State can amend its Medicaid State plan to require Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used for PIHP or PAHP programs.

II. GENERAL DESCRIPTION OF THE PROGRAM AND PUBLIC PROCESS

1. Describe the types of entities with which the State will contract, and indicate whether the contract is a comprehensive risk contract. Include the payment method to be utilized (i.e. fee for service or capitation).

2. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the State will use to ensure ongoing public involvement once the state plan has been implemented.

   Carolina ACCESS (CA), implemented in 1991, is the Division of Medical Assistance (DMA) primary care case management (PCCM) program in which the primary care provider (PCP) coordinates patient care and acts as a gatekeeper. Providers are reimbursed fee for service and the PCPs receive a management fee for each recipient. The PCPs receive a management fee of
   $ 1.00 per member per month.

   ACCESS II, launched in July of 1998, is an enhanced primary care case management program in which Carolina ACCESS PCPs have joined together to form distinct networks headed by an administrative entity. The networks have developed care management and disease management strategies targeted to their respective populations. The PCPs receive a management fee of $ 2.50 per

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member per month and all providers are paid on a fee-for-service basis. The administrative entity receives an additional management fee of $ 2.50 per member per month for the enhanced services.

Carolina ACCESS is the largest of the three programs and is viewed as the cornerstone of Medicaid managed care. ACCESS II is an enhancement of the Carolina ACCESS PCCM model. As of October 1, 2001, ACCESS II was operational in Mecklenburg County.

Health Care Connection, which began operating in June of 1996, is the State's HMO program in Mecklenburg County. Recipients have the choice of enrolling in the one participating Managed Care Organization (MCO), Carolina ACCESS, ACCESS II or with a Federally Qualified Health Center (FQHC).

A DMA Managed Care Section staff member regularly attends the North Carolina Commission on Children with Special Health Care Needs meetings that are held bi-monthly. This is a Governor-appointed group that was established as part of the Health Choice (CHIP) legislation in 1997.

The Governor's Commission on Children with Special Health Care Needs (CSHCNs) is the appropriate avenue for addressing care coordination issues amongst systems of care in North Carolina. The Commission members consist of a primary and a tertiary care provider in private and public practices, parents of a child with special needs, a local Health Department Director, a Special Education expert, a psychologist and a psychiatrist. In addition to the Commission Members, regular attendees include Division of Public Health (DPH) staff supporting the Commission, DPH Therapy Services staff, Assistive and Augmentative Devices staff, Division of Medical Assistance Managed Care staff, DMA/DPH Health Choice (SCHIP) staff, Early Intervention staff, State Health Plan Blue Cross/Blue Shield staff (administrators of the Health Choice (SCHIP program in NC) and Value Options staff, whom are involved in prior authorization activities for behavioral health services.

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Members of this group present information regarding the activities of these agencies and discussed issues regarding care coordination and any other issue involving CSHCNs.

The State distributes Health Plan Employer Data and Information Set (HEDIS), [a set of standardized performance measures designed to reliably compare the performance of managed health care plans] data to Governor's Commission on Children with Special Health Care Needs as a means to identify issues that the Commission may need to address.

Attendance at the Commission's meetings is beneficial to DMA's Managed Care staff. The insight and guidance provided by the Commission members helps DMA in developing proposals. DMA plans to continue its attendance at the Commission meetings to maintain the access to input provided by stakeholder and consumers that this committee provides.

Recipients enrolled with the PCCM managed care option have public input through the Division's toll free hotline number that is manned from eight to five, Monday through Friday by Managed Care staff. Voice mail is available after hours for the recipient; the appropriate managed care staff person will return their call as soon as possible.

PCCM enrolled recipients also have public input through the Recipient Complaint Process. It is a mechanism to ensure providers are meeting contractual obligations and enrollees have access to appropriate and timely care. An internal complaint policy has been developed to ensure timely and consistent processing of complaints. The complaint process is described below:

If an enrollee has a complaint against the provider, the enrollee may seek resolution by submitting a completed and signed Carolina ACCESS Complaint form to the address indicated on the form. A copy of the form is available on website or from the county DSS. If the enrollee requires assistance with the Compliant Form, they may contact their caseworker at the county DSS office or call the Managed Care toll free number.

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Complaints usually fall into one of the following five categories:
1. contract violations/program policy
2. professional conduct – general
3. professional conduct – physical, sexual or substance abuse
4. quality of care
5. program fraud/abuse

Enrollees who complete and sign the complaint form will receive a letter acknowledging receipt from the Quality Management Unit within 7 days of receipt. Upon receipt of a complaint, it is routed to the appropriate Managed Care staff person for action and resolution. Enrollees will not be notified of the outcome of the complaint due to confidentiality policies.

III. ASSURANCES AND COMPLIANCE WITH THE STATUTE AND REGULATIONS

The State plan program meets all the applicable requirements of:

- Section 1903 (m) of the Act, for MCOs and MCO contracts.
- Section 1905 (t) of the Act for PCCMs and PCCM contracts.
- Section 1932 (including Section (a)(1)(A)) of the Act, for the State's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities.
- 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C)
- 42 CFR 438 for MCOs and PCCMs.
- 42 CFR 434.6 of the general requirements for contracts.

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- 42 CFR 438.6 (c) of the regulations for payments under any risk contracts.
- 42 CFR 447.362 for payments under any nonrisk contracts.
- 45 CFR part 74 for procurement of contracts.

IV. ELIGIBLE GROUPS

A. LIST ALL ELIGIBLE GROUPS THAT WILL BE ENROLLED ON A MANDATORY BASIS

With the exception of the populations listed in IV.B, recipients in the following aid categories will be required to enroll in one of the managed care programs described above:

- Work First for Family Assistance (formerly AFDC)
- Family and Children's Medicaid without Medicaid deductibles (formerly AFDC-related)
- Medicaid for the Blind and Disabled (MAB, MAD, MSB)
- Residents of Adult Care Homes (SAD)
- Qualified Alien

Children under age 19 identified as Children with Special Health Care Needs, dual eligibles, and Indians who are members of a Federally recognized tribes are exempt from mandatory enrollment.

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B. MANDATORY EXEMPT GROUPS

1. Recipients who are eligible for Medicare

__X__ The State will allow these individuals to voluntarily enroll in the managed care program.

Dual Eligibles will be allowed to voluntarily enroll in Carolina ACCESS or ACCESS II. Dual Eligibles are not allowed to enroll in the Mecklenburg County MCO.

2. Indians who are members of Federally recognized tribes except when the MCO or PCCM is the Indian Health Service; or an Indian Health program or Urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement or compact with the Indian Health Service.

__X__ The State will allow these individuals to voluntarily enroll in the managed care program.

3. Children under the age of 19 years, who are eligible for Supplemental Security Income under Title XVI.

__X__ The State will allow these individuals to voluntarily enroll in the managed care program.

4. Children under the age of 19 years who are eligible under section 1902(e)(3) of the Act.

____ The State will allow these individuals to voluntarily enroll in the managed care program.

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5. Children under the age of 19 years who are foster care or other out-of-the-home placement.

   _X_ The State will allow these individuals to voluntarily enroll in the managed care program.

6. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E

   _X_ The State will allow these individuals to voluntarily enroll in the managed care program.

7. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the state in terms of either program participation or special health care needs.

   _X_ The State will allow these individuals to voluntarily enroll in the managed care program.

C. LIST ALL OTHER GROUPS THAT ARE PERMITTED TO ENROLL ON A VOLUNTARY BASIS

   Community Alternative Program (CAP) Enrollees are allowed to enroll in Carolina ACCESS and ACCESS II.

1. Is the State's definition of these children in terms of program participation or special health care needs?

   The State defines these children in terms of special health care needs and program participation in Development Evaluation Center (DEC) and Child Special Health Services (CSHS).

Approval Date: NOV 18 2003 Eff. Date: 8/13/2003

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2. Does the scope of these Title V services include services received through a family-centered, community-based, coordinated care system?
Title V program participants are identified as those receiving DEC services and CSHS.

3. How does the State identify the following groups of children who are exempt from mandatory enrollment:

   a. Children under 19 years of age who are eligible for SSI under Title XVI;

      The State identifies this group by Medicaid eligibility category of assistance.

   b. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

      The State does not enroll this population in the managed care programs.

   c. Children under 19 years of age who are receiving foster care or adoption assistance under title IV-E of the Act.

      The State identifies this group by the Medicaid eligibility category of assistance.

4. What is the State's process for allowing children to request an exemption based on the special needs criteria as defined in the State Plan if they are not initially identified as exempt from mandatory enrollment?

   Enrollment in a managed care program health care option is voluntary for Children with Special Health Care Needs (CSHCN).